



PRE-ADMISSION EVALUATION (PAE) FOR ICF/MR LEVEL OF CARE

Mail to: **Division of Developmental Disability Services, P. O. BOX 450, NASHVILLE, TN 37202-0450**

<<This section to be completed by Medicaid>>

DECISION		APPROVED		REVIEWED BY	REVIEW DATE	SERVICE TYPE
NO	YES	FROM	THROUGH			
[]	[]	_____	-- _____	_____	_____	[] ICF/MR
[]	[]	_____	-- _____	_____	_____	[] HCBS waiver (specify type)
[]	[]	_____	-- _____	_____	_____	

NOTE: A PAE that has not been used within 90 days of the approved "From Date," must be updated before it can be used.

SERVICE REQUESTED

- [] "Statewide" HCBS Waiver
- [] "Self-Determination" HCBS Waiver
- [] "Arlington" HCBS Waiver
- [] ICF/MR facility

SECTION I: GENERAL INFORMATION

PROVIDER Name _____

Provider Street Address _____

Provider City/State/Zip _____

Provider Contact Person _____ Provider # _____

Provider Phone # _____ Fax # _____

REASON FOR PRE-ADMISSION EVALUATION

- [] NEW ADMISSION into ICF/MR or HCBS waiver program
- [] TRANSFER from another ICF/MR or HCBS waiver program
- [] UPDATE of previously approved PAE
- [] Other (specify): _____

PRIOR SERVICES

- [] Yes Was the person receiving Medicaid-reimbursed care in an Intermediate Care Facility for the
- [] No Mentally Retarded or in an HCBS waiver for the mentally retarded on or prior to September 5, 2000?

RECIPIENT _____, _____, _____
(Last Name) (First) (Middle)

Street Address _____

City/State/Zip _____

Sex _____ Age _____ Date of Birth _____ Telephone Number _____

Medicaid ID Number _____ Social Security Number _____

DESIGNATED CORRESPONDENT _____, _____, _____
(Last Name) (First) (Middle)

Street Address _____

City/State/Zip _____ Telephone Number _____

Legal Relationship: [] Guardian [] Conservator [] Parent with legal custody of recipient (if under 21)

RECIPIENT'S NAME _____ MEDICAID ID # _____

SECTION II: PSYCHOLOGICAL EVALUATION

LEVEL OF MENTAL RETARDATION ☐ Mild ☐ Severe
☐ Moderate ☐ Profound

IQ TEST SCORE* _____ DATE OF TEST _____ TYPE OF IQ TEST _____

* If an I.Q. test can not be appropriately administered due to the young age (age 4 or younger) of the person, please attach a letter of explanation with information about the person's diagnosis and developmental disabilities.

REQUIRED ATTACHMENTS - A psychological examination performed within the preceding 12 months must be submitted with the PAE. If the psychological exam was not performed within 90 days preceding the date of the PAE, the psychological examination must be updated by the person who performed the examination or by the supervising clinical psychologist who signed the initial evaluation.

SECTION III: ASSESSMENT OF CAPABILITIES AND NEEDS

BATHING (Choose the single best answer.)

- ☐ Capable of bathing without assistance.
- ☐ Capable of bathing but requires some assistance (e.g., setting up the bath, adjusting the water temperature, assistance into the bath, encouragement to bathe, or assistance with clothing).
- ☐ Incapable of bathing without continual supervision and assistance and requires assistance with multiple bathing functions in order to complete the bathing process.

COMMUNICATION, EXPRESSIVE (Communication Not Limited Just To Speech) (Choose the single best answer.)

- ☐ Capable of communicating information to others (e.g., presence of pain, need for assistance with toileting)
- ☐ Usually capable of communicating basic needs to others but may have some difficulty.
- ☐ Usually incapable of communicating basic needs (verbally or nonverbally) to others.

EATING/FEEDING (Choose the single best answer.)

- ☐ Feeds self with a spoon or with a fork without assistance.
- ☐ Capable of self-feeding with a spoon or with a fork but requires some assistance (e.g., setting up the food tray, cutting up meat, or simple encouragement to eat or to eat less rapidly).
- ☐ Incapable of self-feeding without continual supervision and assistance with multiple eating problems (excluding supervision of obesity or weight reduction)
- ☐ Requires feeding by nasogastric or gastrostomy tube.

MOBILITY BY AMBULATION OR WHEELCHAIR (Choose the single best answer.)

- ☐ Capable of mobility by ambulation or wheelchair without assistance.
- ☐ Capable of mobility by ambulation or wheelchair but may require either mechanical assistance (walker, crutch, cane, or other mobility aid), standby assistance, or occasional physical assistance provided by others.
- ☐ Usually or always incapable of mobility by walking and by use of a wheelchair unless physical assistance is provided by others.

ORIENTATION TO SELF (Is Aware Of Own Name) (Choose the single best answer.)

- ☐ Oriented
- ☐ Occasionally disoriented.
- ☐ Disoriented to self (cannot remember own name) all or most of the time.

ORIENTATION TO PLACE (Is Aware Of Current Place Of Residence) (Choose the single best answer.)

- ☐ Oriented
- ☐ Occasionally disoriented.
- ☐ Disoriented to place (is not aware of current place of residence) all or most of the time.

RECIPIENT'S NAME _____ MEDICAID ID # _____

PRESCRIPTION MEDICATION, ABILITY TO SELF-ADMINISTER (oral/ophthalmic/topical/inhaler) (Choose the best answer.)

- ☐ Takes no prescription medications.
- ☐ Capable of taking or using prescription medications without assistance or supervision.
- ☐ Capable of taking or using prescription medications when limited assistance or supervision is provided (i.e., reminding when to take, encouragement to take, reading labels, opening bottles, reassuring person of correct dose).
- ☐ Repeatedly is noncompliant with medically necessary prescription medications and requires continual supervision and very strong encouragement to achieve medication compliance.
- ☐ Requires prescription medications which, in accordance with accepted medical practice, are not routinely self-administered.

TOILETING AND TOILETING HYGIENE (Choose the single best answer.)

- ☐ Can use a toilet and care for toileting hygiene without assistance.
- ☐ Can use a toilet and usually can care for toileting hygiene; requires supervision and minor assistance (e.g., adjustment of clothing, assistance with hygiene).
- ☐ Incapable of self-execution of toileting or toileting hygiene in the absence of continual supervision and assistance provided through a systematic program of habilitative training.

TRANSFER (Ability To Move From Bed To Chair Or From Chair To Bed) (Choose the single best answer.)

- ☐ Capable of self-transfer.
- ☐ Usually capable of self-transfer but occasionally may require assistance from others or standby assistance.
- ☐ Incapable of self-transfer.

VISION (Choose the single best answer.)

- ☐ Sees adequately in all or most situations.
- ☐ Capable of seeing large print, simple pictures, and obstacles, but not details.
- ☐ Cannot find way around without feeling or using cane.
- ☐ Totally blind.

BEHAVIOR (Check yes or no.)

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | The person has a behavior disorder of such severity that the absence of an ongoing program of behavior modification therapy would reasonably be expected to seriously endanger the life of the person, to result in severe self-inflicted injury, to cause severe injury to others, or to seriously endanger the lives of others. |

Please describe the behavior and attach supporting documentation (e.g., behavior incident reports):

By my signature, I certify that the above assessment has been performed by me, and that, to the best of my knowledge, the assessment is accurate and true.

Signature of physician, physician's assistant, nurse, psychologist, social worker (BSW/MSW), special education teacher/instructor, or DMRS Intake Staff Person

NAME (Please print) _____ DATE _____

SIGNATURE _____ TITLE _____

RECIPIENT'S NAME _____ MEDICAID ID # _____

SECTION IV: MEDICAL INFORMATION

DIAGNOSES PRIMARY _____

 SECONDARY _____

 OTHER _____

HISTORY & PHYSICAL (Please attach a current history and physical).

CURRENT MEDICATIONS (Current physician's orders may be attached. If so, please mark "See attached".)

Name		Route/dosage/frequency		Name		Route/dosage/frequency	
1	_____		_____	5	_____		_____
2	_____		_____	6	_____		_____
3	_____		_____	7	_____		_____
4	_____		_____	8	_____		_____

PLAN OF CARE FOR ICF/MR INSTITUTIONAL SERVICES: Complete this section only for institutional ICF/MR Services and include habilitative and other services needed. For HCBS Waiver program services, please complete Section V (Plan of Care for HCBS Waiver Services).

RECIPIENT'S NAME _____ MEDICAID ID # _____

SECTION V: PLAN OF CARE FOR HCBS WAIVER SERVICES

(Complete this section only for HCBS Waiver program services. List amount, frequency, and duration of requested services.)

WAIVER SERVICE	AMOUNT	FREQUENCY	DURATION
Support Coordination			
Transitional Case Management			
Residential Care <input type="checkbox"/> Supported Living <input type="checkbox"/> Residential Habilitation <input type="checkbox"/> Family Model Residential Support <input type="checkbox"/> Medical Residential Services			
Personal Assistance			
Day Services			
Transportation Services, Individual			
Respite Services			
Behavioral Respite Services			
Behavior Services			
Dental Services, Adult			
Nursing Services (Specify the specific licensed nursing service that the enrollee requires): _____ _____			
Nutrition Services			
Physical Therapy			
Occupational Therapy			
Orientation and Mobility Training			
Speech, Language, & Hearing			
Personal Emergency Response Systems			
* Environmental Accessibility Modifications			
* Specialized Medical Equipment/Supplies, Assistive Tech.			
* Vehicle Accessibility Modifications			
Vision Services ("Arlington" waiver only)			

* Specify item(s) being requested. _____

RECIPIENT'S NAME _____ MEDICAID ID # _____

SECTION VI: PHYSICIAN'S CERTIFICATION

BY MY SIGNATURE, I CERTIFY THE FOLLOWING:

- a. that the person needs the services of a qualified mental retardation professional (QMRP) on an ongoing basis to improve the person's functional ability, to prevent the person's condition from deteriorating, or to delay loss of functional ability, AND
- b. that the person requires inpatient care in an Intermediate Care Facility for the Mentally Retarded or services provided through an HCBS waiver for the mentally retarded and that the person requires a continuous active treatment program for mental retardation, AND
- c. that, to the best of my knowledge, all information shown on this form is accurate and true.

NAME OF PHYSICIAN _____ PROVIDER # _____

PHYSICIAN'S SIGNATURE _____ DATE _____

PHYSICIAN'S SIGNATURE (**update**) _____ DATE _____

PHYSICIAN'S SIGNATURE (**update**) _____ DATE _____

RETROACTIVE REQUESTS only: I certify that the patient's medical condition existed on this date: _____

PHYSICIAN'S SIGNATURE _____ DATE _____